Psychotherapy of Personality Disorders

Metacognition, States of Mind and Interpersonal Cycles

Giancarlo Dimaggio, Antonio Semerari,
Antonino Carcione, Giuseppe Nicolò and Michele Procacci

Psychotherapy of Personality Disorders

'Dimaggio, Semerari and colleagues have creatively constructed a cognitive constructivist model of psychopathology and psychotherapy that thoughtfully integrates cutting edge theory and research regarding personality disorders, attachment and developmental psychology, cognitive science and neuroscience, interpersonal and emotional processes and the therapeutic relationship. The result is a rich rendering of the psychotherapy process with personality disorders that readily moves back and forth from the presentation of sophisticated ideas, often grounded in empirical research, to accessible applications and clinical illustrations – a treatment guide that is at once scholarly and practical.'
J. Christopher Muran, Chief Psychologist, Department of Psychiatry, Beth Israel Medical Center

'This is an important and intriguing contribution to understanding and treating personality disorder by a group of authors who are doing some of the most interesting contemporary work in the field. The volume offers an innovative perspective that extends our understanding of personality disorder by describing fundamental metacognitive processes underlying personality and interpersonal functioning. This work will appeal to both researchers and clinicians: those studying the disorder will appreciate the in-depth analysis of personality pathology and clinicians will benefit from the sophisticated examination of the reasons why the disorder is so intractable and thoughtful suggestions for treatment strategies.'
John Livesley, University of British Columbia

'In this remarkable volume, the authors present a theoretical perspective that not only achieves their stated goal of advancing the understanding and treatment of personality disorders, but also unstated goals whose achievement makes the work of exceptionally broad significance to psychological science. In a seamlessly coherent three-part attack on problems of personality disorder, the authors provide (1) principles for identifying and classifying types of disorder; (2) theoretical analyses of intra-psychic and

interpersonal dynamics that are characteristic of each type; and (3) practical therapeutic principles that are firmly grounded in the basic theory. Yet they do even more than this. In the psychological science of persons, there is often a gap between classificatory, taxonomic efforts, on the one hand, and analyses of intra-individual personality dynamics, on the other. Taxonomists provide simple descriptive schemes, but sometimes at the cost of portraying the individual simplistically. Students of personality dynamics grapple with the complex interplay among biological, cognitive, and social processes, but commonly fail to address the practical need for taxonomic classification. In a manner that is rare, if not utterly unique, in contemporary personality science, the authors advance practical classificatory principles while simultaneously treating the subjects being classified – evolved, socioculturally situated, self-reflective, meaning-constructing, agentic, coherent individuals – with the complexity they deserve. The book accomplishes all of this with exceptional scientific breadth and intellectual sophistication.'
Daniel Cervone, University of Illinois, Chicago

An accurate description of the problems associated with personality disorders can lead to psychotherapists providing better treatment for their patients, alleviating some of the difficulties associated with handling such disorders. The authors draw on existing therapeutic approaches and concepts to offer a treatment model for dealing with personality disorders.

Psychotherapy of Personality Disorders clearly discusses the models for different types of personality disorder, along with general treatment principles, focusing on:

- Principles for identifying and classifying types of disorder
- Theoretical analyses that are characteristic of each type
- Practical therapeutic principles that are grounded in the basic theory.

The language is clinician-friendly and the therapeutic model is illustrated with clinical cases and session transcripts making this title essential reading for psychotherapists, personality disorder researchers and cognitive scientists as well as professionals with an interest in personality disorders.

The Authors are all founding members of the Third Centre of Cognitive Psychotherapy, Trainers for the Italian Society of Behavioural and Cognitive Therapy (SITCC) and Trainers of the Association of Cognitive Psychology (APC).

Guest contributors: Laura Conti, Donatella Fiore, Daniela Petrilli, Raffaele Popolo, Giampaolo Salvatore, Maria Sveva Nobile.

Psychotherapy of Personality Disorders

Metacognition, States of Mind and Interpersonal Cycles

Giancarlo Dimaggio, Antonio Semerari, Antonino Carcione, Giuseppe Nicolò, Michele Procacci

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2007 by Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Simultaneously published in the USA and Canada
by Routledge
270 Madison Avenue, New York, NY 10016

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Psychotherapy of personality disorders : metacognition, states of mind, and interpersonal cycles / [edited by] Giancarlo Dimaggio . . . [et al.].
p. ; cm.
Includes bibliographical references and index.
ISBN-13: 978-0-415-41270-4 (hbk)
ISBN-10: 0-415-41270-6 (hbk)
1. Personality disorders–Patients–Treatment. 2. Psychotherapy.
I. Dimaggio, Giancarlo.
[DNLM: 1. Personality Disorders–therapy. 2. Personality Disorders –diagnosis. WM 190 P641 2006]
RC554.P759 2006
616.85'82–dc22

2006011791

ISBN 0–203–93953–0 Master e-book ISBN

ISBN: 978-0-415-41270-4 (hbk)

Contents

Authors and guest contributors

The authors

All the authors and guest contributors are members of the Third Centre of Cogntive Psychotherapy, Rome. This book stems from the work performed in the Centre. They are all trainers of the Schools for Cognitive Psychotherapy – Associazione di Psicologia Cognitiva (APC) and Scuola di Psicoterapia Cognitiva (SPC).

Antonino Carcione, MD, psychiatrist and psychotherapist, has written papers about the psychotherapeutic process and pathology and treatment of personality disorders in Italian and international journals. He is co-editor of the journal *Cognitivismo Clinico*.

Giancarlo Dimaggio, MD, psychiatrist, psychotherapist. Trainer of the Società Italiana di Psicoterapia Cognitiva e Comportamentale (SITCC). He has published about 40 papers and book chapters about pathology and treatment of personality disorders, about personality psychology and self theory in English journals, plus many others in Italian and Spanish journals. He's been guest editor of a special issue for the *Journal of Constructivistic Psychology* and of a forthcoming issue of the *Journal of Clinical Psychology: In-Session*. He is a member of the editorial board of the *Journal of Constructivistic Psychology* and associate editor of the *International Journal for Dialogical Science*. With Hubert Hermans he's co-edited the book *The Dialogical Self in Psychotherapy*.

Giuseppe Nicolò, MD, psychiatrist and psychotherapist. President of the European Chapter of the SPR, Head of a Centre of Mental Health, Rome. Responsible for the School of Specialization in Cognitive Psychotherapy SPC in Reggio Calabria (Italy). He has written papers about the psychotherapeutic process and pathology and treatment of personality disorders in Italian and international journals.

Michele Procacci, MD, psychiatrist and psychotherapist. Head of an outpatient Mental Health Service in Rome. Professor of Psychopathology,

University of Naples and trainer at the SITCC. He has written papers about cognitive neuropsychiatry and the pathology of personality disorders in Italian, Spanish and international journals.

Antonio Semerari, MD, psychiatrist, psychotherapist. Trainer of the SITCC. He has been president of the Italian Chapter of the Society for Psychotherapy Research (SPR). Among his works are: *I processi cognitivi nella relazione terapeutica* (Rome 1991) (*Cognitive processes in therapeutic relationship*); *Psicoterapia cognitiva del paziente grave* (ed.) (Milan 1999) (*Cognitive psychotherapy of severe patients*); *Storia, teorie e tecniche della psicoterapia cognitiva* (Rome 2002) (*History, theories and techniques of cognitive psychotherapy*).

Guest contributors

Laura Maria Conti, Ph.D., psychologist and psychotherapist. She has written papers about the psychotherapeutic process and pathology and treatment of personality disorders in Italian and international journals.

Donatella Fiore, MD, psychiatrist and psychotherapist. She has written papers about the psychotherapeutic process and pathology and treatment of personality disorders in Italian and international journals.

Maria Sveva Nobile, MD, child and adolescent psychiatrist and psychotherapist.

Daniela Petrilli, Ph.D., psychologist and psychotherapist.

Raffaele Popolo, MD, psychiatrist and psychotherapist. Vice-President of the Italian section of the Psychotherapy Research Society. He has written works on the psychotherapeutic process, particularly regarding patients suffering from social anxiety.

Giampaolo Salvatore, MD, psychiatrist and psychotherapist. He is trainer at the International School of Psychotherapy in the Institutional Setting (SIPSI, Rome). He has written papers about the psychotherapeutic process, pathology, the treatment of personality disorders and schizophrenia in Italian and international journals. He is author of the book: *Il Tao della Psicoterapia* (*The Tao of Psychotherapy*).

Acknowledgement

This book was written with the support of a grant received by Fondazione Anna Villa e Felice Rusconi.

Chapter 1

The perpetuation of personality disorders: a model

Giancarlo Dimaggio, Antonio Semerari, Antonino Carcione, Giuseppe Nicolò and Michele Procacci

Defining personality disorders

The concept that the way in which an individual relates to others can in itself be pathological is today well accepted (Livesley 2001a). Personality gets created out of various mental operations: building self-image, ascribing meaning to the world, performing actions, relating with others and finding solutions to the problems presented by one's social environment. There can be a malfunctioning of these operations and, when this spreads to wide areas of interpersonal and inner life, it takes a personality disorder (PD) form.

Clinical experience and empirical research show that comorbidity in PDs worsens a prognosis on axis I, slows down any response to treatment and makes it less effective (Pilkonis and Frank 1988). In particular, it worsens the prognosis for depression (Charney *et al*. 1981; Frances *et al*. 1986; McGlashan 1987; Shea *et al*. 1990). There are similar data for anxiety, somatoform and substance abuse disorders (Reich and Vasile 1993; Stein *et al*. 1993). Taking a wider view, embracing how individuals organise their inner world, together with relations with others and group affiliation (i.e. the functions of the personality), is essential.

Our book is based on the following assumptions: (1) PDs are categorised by prototypes, featuring common aspects, which get expressed in identifiable modes of intrapsychical and interpersonal functioning (Millon and Davis 1996; Westen and Shedler 2000); (2) each different prototype presents separate clinical problems.

It is indispensable that a pathological type and how it functions be diagnosed correctly if we are to deal with the real problems, not waste time in futile tasks, make treatment more effective and reduce drop-out rates. The central question we are trying to answer is: *how are we to explain why a disorder persists and perpetuates itself?* Let us imagine a man whose life theme is inadequacy, coupled with feeling embarrassed. When he starts a relationship, he expects to be derided and rejected. Let us take this imaginary exercise further: he is not a skilled psychologist and does not

have the ability to perceive what others think from their expressions or behaviour. He interprets their every communicational signals as contempt, and from their every glance he deduces that his failings are on view. For example, at a job interview he would see the interviewer as scornful towards him and, feeling embarrassed, would clam up. At the end of the interview he would feel disappointed and leave the other with a negative impression.

Let us now imagine a man who has the same feelings of worthlessness and embarrassment but possesses an excellent ability to read others' minds. He would go to a job interview full of anxiety and sure that his failings will be discovered. However, the examiner makes an appreciative gesture, which our subject perceives is undoubtedly sincere. He feels more relaxed and his performance is convincing. He gets hired. Using the information he has picked up from the relationship, he realises he is over-concerned about negative opinions. He continues to be prone to embarrassment, but is able to receive some satisfaction from relationships and to modulate his negative emotions. Can the reader see avoidant personality disorder in the first example?

This example encapsulates our reasoning, with an analysis of two distinct psychological dimensions. The first is the life theme, with the emotions distinguishing it, and the second is the ability to perceive others' states of mind. The life theme generates pathogenous expectations, and a lack of psychological skills makes them permanent and prevents an individual from taking advantage of any information that might invalidate them. The individual in the second example possesses psychological skills and looks at himself and the world from a different perspective. Our line of reasoning will consistently adopt the following procedure: *identifying a disorder, breaking it up into the various dimensions of which it is composed and tracing how they interact with each other over time*.

We are, therefore, creating a *psychopathology model* (Dimaggio *et al.* 2002; in press a) and giving an official form to treatment models suitable for tackling the problems and vicious circles specific to each disorder.

The main dimensions can be found with the assistance of the following questions: (a) *what do individuals think and feel?* Hence the attention given to the meaning system; (b) *how much are they able to access their own and others' thoughts?* The theory about the ability to metarepresent states of mind (metacognition) provides a reply; (c) *how do they elicit reactions confirming their expectations?* Hence the focusing on interpersonal processes; (d) *how do they make choices and what principles guide them?* We then look at decision-making processes, action triggers and forms of reasoning.

A number of authors have tried to find replies to these questions. Millon (1999) gives importance to how cognitive elements interact with defence mechanisms, interpersonal styles, schemas, needs and motivations, giving rise to a holistic way of functioning which is constant over time. A clinician's goal is to 'take the whirling currents of a subject's behaviour and

extract a set of underlying logical principles encapsulating accurately his/her functioning' (Millon and Davis 1996: 9). According to Perris (1993) the main factors are: (a) the motivational and affective system, which leads to an active construction of the world, an organisation of knowledge and the emergence of a sense of identity; (b) a person's genetic wealth; (c) experiences connected with how individuals were reared by their parents; (d) information-processing heuristics; and (e) internal working models.

Evolutionary psychologists maintain that individuals have some fundamental goals and strategies they pursue in order to live in a group and through that group ensure their survival (Buss 1995). Behaviour disorders become significant when such processes get altered (Plutchik 1980; Livesley 2001b; Gilbert 2005). In certain pathologies, for example, an essential aspect is the process of trying to maintain a protective distance from others: when persons are convinced that they have failed to keep an optimal distance from a reference figure (attachment motivation in which thoughts and emotions acquire meaning), this causes them suffering and leads them to underrate emotional signals (*coping* mechanism) and to maintain a distance from others. As one can see, in this case there are different psychological dimensions sustaining a disorder in which it is possible to identify the core avoidant personality features.

Ryle and Kerr (2002) place emphasis on three dysfunctional phenomena: (1) self–other reciprocal roles manifesting themselves in impoverished or dangerous forms of self-care and of relating with others; based on such interactive procedures, patients enter into relationships that reinforce their pathologies; (2) dissociation between patterns, i.e. a lack of integration between various role models, due to not being able to control one's emotional experience, which is traumatic from childhood; (3) low self-reflectivity.

However, before we put together any hypotheses, it is essential to take a look at the debate currently under way on what a PD is, how it is composed, whether there are any easily identifiable nosographic categories and what they are. In this book we propose models for the various disorders on the assumption that they exist, and are identifiable and distinct from each other. In reality, providing a description of the disorders of this sort is not a task solved once and for all (Livesley 2001b).

How to classify personality disorders: by dimensions, categories or prototypes?

The introduction of a specific diagnostic axis for PDs in *DSM III* led to an enormous growth in research and clinical observations about them, and at the same time to controversies and problems. With the preparation of *DSM V*, there has been a rekindling of the discussion. Its authors ask themselves: how can one define a PD in general? And distinguish between the various disorders? What is the best strategy for achieving a new classification?

The general PD definition provided by *DSM IV-TR* (APA 2000) highlights the following distinguishing elements: it arises in early adulthood, is durable over time, is inflexible and pervasive in character in one's various life areas, and has consequences in terms both of subjective suffering and of the limitations it causes in relationships and at work.

The most important controversy is about which type of diagnosis best encapsulates the characteristics of PDs and the differences between them: dimensional or categorical.[1] In medicine essential hypertension is a perfect example of dimensional diagnosis: a critical point along a continuum (the arterial pressure level) is where there starts to be a disorder and beyond it one can define the illness in quantitative terms. A heart attack, on the other hand, produces a qualitative discontinuity with the pre-existing situation; the set of biological and clinical variables determining it is an obvious category. Should the PDs be described in terms of category, as currently in *DSM*, or do we need to switch to a dimensional approach? There are two arguments favouring the dimensional model. The first can be presented in the form of a syllogism. The major premise is that the PDs are pathological variants within a general theory regarding normal personality. The minor premises are that current theories describe a normal personality in terms of traits and that these traits are continuous dimensions. The conclusion is that a PD should be considered an extreme variation on the basic traits (Cloninger *et al.* 1993; Costa and Widiger 2002).

The second is empirical-methodological. One of the problems with the present categorical definition is the high number of co-diagnoses both

1 Another problem is that the definition provides a good description of the essential elements of the disorders but raises a difficulty: it does not clearly and definitively distinguish between PDs and the disorders on axis I. The definition could in fact be applied, for example, to dysthymia or schizophrenia (Oldham and Skodol 2000). Between one crisis and the next, patients with anxiety disorders use, in construing the world, the same constructs as when displaying the symptoms and their reactions are less intense but with the same range of emotions. An asymptomatic phobic individual always judges the world in terms of liberty/constraints and presence/closeness of an attachment figure, which may lead to some minor interpersonal problems. Vice versa, borderline patients' functioning is not constantly pathological and can, indeed, go through periods of stability and social adaptability, which are characteristics of symptomatic disorders (Livesley 2001a). From a constructivist point of view, the important question is not to create separate axes but to understand how a personality is organised and what structure an individual gives to his/her inner experience. How a personality is organised can, when in contact with the world, lead to symptoms, overall dysfunctions or pathological relationships (Kelly 1955; Guidano and Liotti 1983). Nor does psychoanalytic theory consider the question. Again it is an alteration in the structure of the personality that generates symptoms (Kernberg 1975). The question probably needs to be put the other way round: it is not so important to put PDs on the same axis as symptomatic disorders, as to demonstrate how they are linked to the underlying personality. Limited alterations to DDP produce symptoms, with more wide-ranging alterations leading to a PD (Millon 2000).

between the various PDs and between these and axis I disorders. On top of the oddity of a person diagnosed with four or more separate PDs (Widiger and Sanderson 1995), there are the problems deriving from the polythetic *DSM* system, with which, as a general rule, it is possible to make the same diagnosis for heterogeneous groups.

For example, given that for a borderline disorder diagnosis it is sufficient to possess five criteria out of nine, it is possible for two patients to receive the same diagnosis with only one common criterion and the others all different. The shortcomings of categorical classification are also considered responsible for the problem of the lack of concordance between diagnostic instruments. This difficulty in obtaining uniform data on one patient in different interviews could reflect problems inherent not in the tools but in the categories themselves (Oldham and Skodol 2000). However, Westen and Shedler (2000) note that the instruments used for diagnosing PDs are self-administered questionnaires, based therefore on patients' supposed ability to provide an accurate and sincere description of their inner state; in other words, the ability, which, by definition, is impaired in these disorders; the diagnostic problems are therefore ascribable to the tools.

The failure of *DSM* to select valid categories gets interpreted by the most radical supporters of the dimensional model as a failure of the categorical model in general: they consider that *DSM* does not single out discrete categories because there are none; pathological personalities, like normal ones, are organised along dimensional lines (Cloninger 2000; Widiger 2000).

Livesley and Jang (2000) maintain that defining PDs as extreme variations of certain traits is an important element but not sufficient: there is no reason for considering that an extreme variation of a trait is in itself pathological. Secondly, a personality consists not only of traits but also of cognitive structures, or ways of thinking and experiencing. A personality is a coherent *organisation* of different elements (Allport 1937; McAdams 1996; Cervone and Shoda 1999). Moreover, it is not to be assumed that the same set of traits leads systematically to identical meaning attribution styles or personality profiles (Cervone 2004). Being very conscientious and at the same time unattractive can manifest itself as obsessive-compulsive disorder (OCD) or, just as easily, as being scrupulous and shy. Listing the ingredients is not enough to be able to visualise the final product. Without using the organisation concept, which constrains the system with principles about the order of meanings, it is utterly impossible to foresee, from a set of basic traits, what personality structure will emerge.

We need to turn the question posed by Widiger and Cloninger upside down. They try to define a category as being a total of trait values. They ought, instead, to answer the opposite question: if an individual displays, for example, low *self-directedness*, low *affective stability* and low *self-transcendence*, will the result necessarily be a borderline disorder profile? It

is clear that the reply is 'no' and that the idea of basing nosography on trait theories is a challenge that fails, methodologically, from the start.

Moreover, trait theories are not good at explaining why an individual's reactions vary in different situations. They do not explain this either in normal personalities or in pathological ones, where the variability is curtailed. There is a good explanation in radical social theories: social constructivism (Gergen 1991), group analysis (Foulkes 1990) and situationism (Endler and Magnusson 1976). These theories are based on the assumption that the social context provides meanings and prescribes an individual's actions and reactions within a reference group, which, as a mental framework, pre-exists individual processes. These theories give rise to the opposite problem to the trait ones: they do not take account of the stability that there is in different situations or of the biological ties moulding behaviour.

If it is complicated for pathological personalities to change stance, it is nevertheless true that nobody always has the same reactions in all social situations. From this point of view, models in which personality emerges from an organisation of characters engaging in dialogue with each other in an individual's imaginal space and each talking from specific positions, account much better for both the variability of that individual's replies in various situations and the real complexity of his or her inner world (Hermans 1996; McAdams 1996; Stiles 1999). From this perspective, each individual is composed of a large number of facets with different characteristics, which take control of action as circumstances change. A man who usually has the humble and submissive look of an employee may, in his relationship with his son, display a dominant face, even if only temporarily.

There is a universal set of underlying motivations behind self's many and various facets: Lichtenberg *et al.* (1992) and Gilbert (1989, 2005) explain human behaviour with a set of behavioural systems that get activated in order to satisfy a person's primary goals, which may be both individual (e.g. hunger or regulation of homeostasis) and interpersonal (e.g. attachment or sexuality). Personality can be described as the style persons adopt in organising these motivations into a consistent system of meanings and relational strategies fostering adaptation. Narrative (Angus and McLeod 2004) is the tool with which they are able to use their many and various representations to create a consistent sense of identity and coordinate their goals with their surrounding social environment. In fact, it is possible to arrive at a theory of the personality that takes account of universal variables, selected for their evolutionary usefulness, without risking the oversimplification of the traits theory.

How do individuals benefit from being equipped with lasting principles organising their social behaviour, and in what way are the personality constructs useful for understanding pathology? Livesley and Jang (2000)

stress the importance of the personality function: what personality does. In a similar way to Gilbert and Lichtenberg, they maintain that it carries out tasks fundamental for adapting to a human social environment. Quoting Plutchik (1980), these tasks are: maintaining a stable identity and hierarchy, including dominance and submission questions; territoriality, including the feeling of belonging; temporality, including loss and separation issues. They see PDs as a failure in one or more of the following three universal existential tasks: (1) putting together a stable and integrated representation of oneself and others; (2) building adaptive interpersonal relationships (signals of non-adaptive relationships are an inability to: (a) develop intimate relationships, (b) function as an attachment figure, (c) form co-operative relationships); (3) achieving a good social functioning by behaving in a pro-social and cooperative manner. Livesley and Jang classify PDs as disturbances of interpersonal conduct, arising from a personality stance.

The supporters of the categorical model do not question the importance of traits in defining personality in general and PDs in particular. However, they point out that the distinction between dimensions and categories can turn out to be less clear-cut than might appear at first sight. Firstly, with a variation in the value of a dimension, the category may differ (Westen and Shedler 2000). For example, hypertension is without doubt a dimensional measure, but *pheocromocytoma* hypertension, when accompanied by other biological and clinical variables, constitutes a category.

As well as considering the organisation concept indispensable, so that it is impossible to foresee what form a set of traits will take, writers who are sceptical about a radically dimensional approach distinguish between separate personality types. This leads them to identify disorder prototypes, which they subject to detailed empirical research. For example, the criteria for borderline disorder are internally homogeneous and this confirms its existence as a category. Intensity and instability of relationships and identity disorder are the elements with the greatest sensitivity and diagnostic specificity (Fossati *et al.* 1999).

In general, *DSM* criteria have been shown to be fairly homogeneous: there appear to be discrete categories, even if there is lack of agreement about what they are. The problem is that the downside of this is that there are superfluous criteria for identifying a disorder and that it encourages the overlapping of diagnoses in the same patient (Westen and Shedler 2000; Shedler and Westen 2004). Essentially, the compilers of the manual, in maximising its internal consistency, have indicated elements that are no more than facets of the same trait, as being different criteria. For example, no less than six criteria for paranoid disorder are superfluous measures of chronic diffidence; and at least four criteria for avoidant disorder have to do with fear of rejection and of a negative opinion. If a disorder has only one face, it is clear that as soon as persons show another, they get diagnosed for another disorder.

Evolutionism and complex systems

There is an attempt by evolutionary psychopathology to solve this trait/category dilemma. Maffei *et al.* (2002) suggest that the psychopathology and etiopathogenesis of PDs are to be understood by way of self-organising processes. Starting from childhood temperament, these lead to disadaptation through the ongoing interaction between elements with a genetic basis and environmental ones.

Liotti's (2002) hypothesis about the origins of borderline PD is similar: starting from a pathological relational core, the attachment style termed 'disorganised', it is possible to trace the origins of the two principal factors in the disorder: emotional disregulation and fragmented identity. These two factors create the preconditions each time that the conditions that led to the disorder get reactivated in an individual (i.e. the attachment system gets triggered), for the disorder persisting. The person in fact looks for attention, while expecting either not to receive it or to be the victim of maltreatment by the same person who ought to be providing it. This renders the person alternately angry, distressed, confident or erotically aroused in the care relationship. The emotionality experienced is intense and contradictory. The other reacts in a confused manner with, in turn, an alternation between giving attention, angry rejection and seductiveness. This in turn confuses and frightens the subject. Fear reactivates the attachment system, which reinforces the interpersonal processes described above and thus gives rise to a vicious circle. In conclusion, to understand PDs it is necessary to establish which adaptive functions are damaged and the level of functioning, and then to avoid over-simplified descriptions of each disorder (Westen and Shedler 2000).

Some of these concepts, in particular those regarding the level of functioning and organisation, have a long psychotherapeutic tradition. Psychoanalysts (Kohut 1971; Kernberg 1975) have drawn attention to a particular type of patient, with a specific organisation and a special level of mental and social functioning, which is different from that of, on the one hand, neurotic patients and, on the other, psychotic ones. With this refinement of the model it is possible to tackle two long-standing treatment problems: difficulties in the therapeutic relationship and the inadequacies of traditional techniques. Problematical interpersonal tendencies tend to get reproduced, and sometimes expanded, by disturbance of mental and social functions. This requires the modifying of the normal strategies and techniques provided for in the psychotherapeutic model. During treatment a psychotherapist gains a direct experience of the force with which a personality organisation pushes others towards relationships that stoke up and reinforce a pathology. In other words, a PD is an organisation of intrapsychical elements shaping a subject's interpersonal sphere so as to stabilise its more dysfunctional aspects. It is thanks, in turn, to this self-organisation

skill that the system evolves with that particular balance between stability and change on which the intuitive concept of personality is based.

The theory we are asserting is that: *every individual possesses distinguishing elements of a different psychological nature (meanings, emotions and emotion-regulation strategies, metacognition and relational styles) and these interact with each other, giving rise to personality prototypes*. An understanding of how the elements making up mental functioning interact with each other, creating *stable organisations* or recognisable styles of intrapsychical and social functioning, is therefore essential.

Dissecting PDs

Our reasoning is that a PD is not a monolith but can be broken down. The first step we take is to identify the basic pathological elements, those involving the alterations occurring in the various areas of mental life. The immediate next step is to look at the interaction between these elements.

The question is typical of the constructivist tradition (Kelly 1955; Guidano and Liotti 1983; Winter 1989; Mancini and Semerari 1990; Neimeyer and Feixas 1990): why, once installed, does a disorder persist? Why do patients not get better spontaneously? The constructivist response used to be: individuals need a meaning system to put their world in order, and adapting to changes means accepting that the system can be invalidated and that attempts to ascribe meaning to the world can be unsuccessful. However, this forces individuals to pass, during the change process, through a period of chaos and, as a result, they 'prefer' to keep up a meaning system, albeit one that has shown itself to be dysfunctional, rather than feel taken over by chaos (Winter 1989; Neimeyer and Feixas 1990). The constructivist explanation is a valid starting point, because it accounts well for the persistence of what are true and proper visions of the world, rather than symptoms. It is, however, inadequate for explaining the persistence of precisely those disorders, i.e. borderline and histrionic, in which a large part of the time is passed in chaos, or those (antisocial) which appear to bestride it even too skilfully. Furthermore, clinical data show that, when PD patients are faced with an invalidation, their reactions are not necessarily chaotic but, on the contrary, are organised skilfully: narcissists withdraw haughtily and disdainfully into their own grandiose world, paranoids anticipate their enemies' movements and dependent personalities specialise in ensuring that reference figures stay close to them.

In building up our model, we have broken the most significant disorders down into their basic elements and then traced the interaction between them, starting with a distinction between mental contents and functions.

What a patient talks about is something different from the ability to define psychological phenomena: identifying a specific emotion is to be

distinguished from the general ability to define emotions. Severe patients display a difficulty, which is sometimes permanent and at other times state-dependent, in their ability to access their inner states, to confront mental phenomena as if they were problems to be solved, and to grasp and be able to express another's point of view. In short, they lack what are termed self-reflective, metacognitive or metarepresentational skills (Leslie 1987; Perris 1993; Baron-Cohen 1995; Fonagy *et al.* 2002; Semerari *et al.* 2003a). For example, because she is excessive in her feelings of personal responsibility, a patient might have a guilt problem, which turns into a depression. However, a clinician, if he is to treat her, needs information on at least one other dimension: how able is she to define her problem? Is she giving a full and clear description of it? Does she grasp causal links and foresee consequences? Is she able to assert: 'It is because of this guilt feeling that I never stop working for others'? Alternatively, the clinician sees only non-verbal signals that lead him to hypothesise about such a problem, while his questions are met with only vague and evasive replies. The level of a patient's metacognition, in this case being able to monitor one's inner state and integrate mental events into a narrative with coherent links, has an impact, therefore, on treatment. If metacognitive skills are poor, clinicians should try to stimulate them, by helping, in this example, to give the emotion its correct name – guilt feeling. If they are well-developed, clinicians should concentrate, as a hypothesis, on encouraging the patient to adopt a critical distance or a problem-solving strategy (Stiles *et al.* 1992).

Two other operations performed by individuals need to be analysed: (a) relating with others; and (b) choosing. Both can be dysfunctional. When added to the first two (organisation of contents and metacognition), we have the full set of areas in which to search for the data necessary for assembling a PD psychological anatomy.

Our approach takes account of dimensional factors, such as metacognition (an individual can be capable of decoding states of mind to various degrees), but provides models for the creation of prototypes. Once we have defined the elements, we can see how a personality emerges from the interaction between them. These processes put in motion dysfunctional circuits that keep a balance between the different variables of which they are composed and create the conditions necessary for social interaction to maintain a disorder. *We consider PDs to be systems that are self-organising, evolutionary and capable of shaping reality in such a way as to ensure their structure gets maintained* (Maffei *et al.* 2002).

Ours is a psychopathological approach, although it has many affinities with developmental and evolutionary theories, paying particular attention to how affective ties get constructed in childhood and are then reactivated during treatment. The hypothesis is that for the etiology of these disorders one should look at the dysfunctions driven by an individual's innate interpersonal tendencies.

What interests us here is how a disorder persists in the present, as a relatively separate subject from how it got activated. Interrupting patients' dysfunctional circuits during therapy has little to do with knowing whether they got formed during their developmental relationship with their parents, by an innate trait, or by their life story (adolescence transition, emigration or whatever). A self-organising system is independent from its initial conditions; to interrupt the process keeping it going, knowing its history is less important than its internal dynamics. It is these that need to be dealt with.

The elements composing disorders

The meaning system: states of mind and impoverished and disorganised discourse

According to narrative theory, individuals organise their meanings in the form of stories (Bruner 1990; McAdams 1996; Habermas and Bluck 2000; Angus and McLeod 2004). These bring together various themes, emotions and visions of the world, and their plots provide events with meaning. When individuals make choices they put together a narrative to compare the current state of the world and their goals with scenarios about what the future might be. Some of these are emotionally agreeable and others unpleasant. They tend to move towards the positively marked and avoid the negative ones. In any case, they weave a story, in which the characters in their internal scenario, which may be real or imaginary, embark on a dialogue, negotiate points of view and take control of the action (Hermans 1996; Stiles 1999; Hermans and Dimaggio 2004). The construction of the narratives gets done in two directions: *bottom-up* (from one's body to one's mind) and *top-down* (from one's culture to one's mind) (Salvatore *et al*. 2004).

In the first case, physical sensations become affectively loaded mental images, portraying the significance of the state of the world for one's organism. For example, the image of a train arriving at top speed is associated with that of the body moving away from the rails, accompanied by fear. Thanks to this mini-story, one is able to choose to move away from the rails, without wasting time on calculating the cost/benefit ratios of the situations that present themselves, and to survive brilliantly. Sequences of images make up proto-narratives (Damasio 1994), which get articulated, become more complex and take on the form of interactive procedures, as described by Stern (1985): *representations of interactions that have been generalised*. These representations get transformed at a second stage into conscious narratives.

The other process of creating stories starts out from individuals' culture and family environment, and provides them with life themes, roads that can